

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

PREAMBLE

- 1. Sections Affected**

	<u>Rulemaking Action</u>
R9-22-705	Amend
R9-22-712	Amend
R9-22-712.35	Amend
R9-22-712.40	Amend
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statute: A.R.S. § 36-2903.01
Implementing statute: A.R.S. § 36-2903.01
- 3. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 13 A.A.R. [Editor to fill in (page #), (date)]
- 4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Mariaelena Ugarte
Address:	AHCCCS
	Office of Legal Assistance
	701 E. Jefferson, Mail Drop 6200
	Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov
- 5. An explanation of the rule, including the agency's reasons for initiating the rule:**

The Administration intends to clarify the coverage and reimbursement requirements related to services provided out-of-state or outside the geographical service area (GSA).
- 6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

None

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

8. The preliminary summary of the economic, small business, and consumer impact:

The Administration anticipates minimal to no impact on small businesses or consumers with the rule changes. These changes provide clarification of how necessary medical services will be reimbursed when received out-of-state or out of the geographical service area.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of December 3, 2007. Please send written comments to the above address by 12:00 p.m., January 22, 2008. E-mail comments will also be accepted during this timeframe.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: January 22, 2008
Time: 10:00 a.m.
Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: January 22, 2008
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-Term Care System
110 South Church, Suite 1360

Tucson, AZ 85701

Nature: Public Hearing

Date: January 22, 2008

Time: 10:00 a.m.

Location: ALTCS: Arizona Long-Term Care System
3480 East Route 66
Flagstaff, AZ 86004

Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-705. Payments by Contractors

R9-22-712. Reimbursement: General

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

TITLE 9. HEALTH SERVICES
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-705. Payments by Contractors

- A.** General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for ~~the~~ provider reimbursement and coordination of care provided for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor ~~at the Administration's capped fee for service schedule rate~~ as specified in this Article if:
 - a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
 - b. The service is emergent under Article 2 of this Chapter.
- B.** Timely submission of claims.
1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.

2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
 3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
 - a. Twelve months from the date of service or for an inpatient hospital claim, twelve months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.
- C.** Date of claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor. A hospital claim is considered paid on the date indicated on the disbursement check. A denied hospital claim is considered adjudicated on the date of the claim's denial. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.
- D.** Payment for inpatient hospital services. A contractor shall reimburse an in-state provider and a noncontracting provider for inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.
- E.** Payment for outpatient hospital services.

1. A contractor shall reimburse an in-state provider and a noncontracting provider for outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904 and R9-22-715.
 2. A contractor shall reimburse an in-state provider and noncontracting provider for outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904 and R9-22-715.
- ~~**F. Inpatient and outpatient out-of-state hospital payments.**~~ A contractor shall reimburse out-of-state hospitals for covered inpatient and outpatient services and associated professional fees provided to an AHCCCS member at the lesser of the negotiated rate, or the rates as described under A.R.S. § 36-2903.01 and this Article.
- F. Inpatient and outpatient out-of-state hospital payments.** A contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01 (6)(b). A contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the claim will be paid by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio. A contractor and an out-of-state hospital may enter into a written agreement that provides for payment on different terms.
- G.** Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45. An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.
- H.** Review of claims and coverage for hospital supplies.
1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.

2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.
4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
 - a. Patient care kit,
 - b. Toothbrush,
 - c. Toothpaste,
 - d. Petroleum jelly,
 - e. Deodorant,
 - f. Septi soap,
 - g. Razor or disposable razor,
 - h. Shaving cream,
 - i. Slippers,

- j. Mouthwash,
 - k. Disposable razor,
 - l. Shampoo,
 - m. Powder,
 - n. Lotion,
 - o. Comb, and
 - p. Patient gown.
6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
- a. Arm board,
 - b. Diaper,
 - c. Underpad,
 - d. Special mattress and special bed,
 - e. Gloves,
 - f. Wrist restraint,
 - g. Limb holder,
 - h. Disposable item used instead of a durable item,
 - i. Universal precaution,
 - j. Stat charge, and
 - k. Portable charge.
7. The contractor shall determine in a hospital claims review whether services rendered were:
- a. Covered services as defined in R9-22-102;
 - b. Medically necessary;
 - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
 - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

- I.** Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.
- J.** Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
 2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
 3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.
- K.** Interest payment. In addition to the requirements in subsection (J), a contractor shall pay interest for late claims as defined by contract.

R9-22-712. Reimbursement: General

- A.** Inpatient and outpatient discounts and penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pended is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).
- ~~**B.** Inpatient and outpatient out-of-state hospital payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient and outpatient services provided to a member at the lesser of the negotiated rate or the AHCCCS FFS rate as described in A.R.S. § 36-2903.01 and this Article.~~
- B.** Inpatient and outpatient out-of-state hospital payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01 (6)(b). AHCCCS shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the claim will be paid by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio. AHCCCS and an out-of-state hospital may enter into a written agreement that provides for payment on different terms.

- C.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.
- D.** Prior authorization. The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210.
- E.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.
- F.** Claim receipt. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number. Hospital claims are considered paid on the date indicated on disbursement checks. Denied claims are considered adjudicated on the date of their denial. Claims that are denied and are resubmitted are assigned new receipt dates. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.
- G.** Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.

 - 1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included

in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:

- a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
 - b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
 3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility. ~~For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.~~

4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7 percent, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) by applying the following formula:

$$CCR*[1.047/(1 + \% \text{ increase})]$$

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

"Existing outpatient services" means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. AHCCCS shall increase the fees established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, as well as hospitals that were public in calendar year 2004.

2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the year in which the rates are effective.
 3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the year in which the rates are effective.
 4. By 115 percent for hospitals designated as Critical Access Hospitals, or for hospitals that have not been designated as Critical Access Hospitals, but meet the criteria.
 5. By 113 percent for a freestanding children's hospital with at least 110 pediatric beds.
 6. By 14 percent for a University Affiliated Hospital defined as those hospitals that have a majority of the member of its board of directors appointed by the Board of Regents.
- B.** In addition to subsection (A) the following increase may be established: A 50 percent adjustment for a Level 2 and 3 emergency department procedures billed by a level 1 Trauma center as defined by R9-22-2101.
- C.** Fee adjustments in subsection (A) are available with the AHCCCS Outpatient Capped Fee-For Service Schedule on file and online with AHCCCS.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

- A.** Procedure Codes. AHCCCS shall add new procedure codes for covered outpatient services and shall either assign the default CCR, the Medicare rate, or calculate an appropriate fee when procedure codes are issued by CMS or the Current Procedural Terminology published by the American Medical Association.
- B.** APC Changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by Medicare. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of the code within the Medicare program is substantially different from the AHCCCS program, AHCCCS may not assign any APC. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in a particular APC group.
- C.** Annual Update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, AHCCCS shall adjust outpatient fee schedule rates:
1. On an annual basis by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or

2. In any given year the director may substitute the increases in (B)(1) by calculating the dollar value associated with the inflationary increase in (B)(1), and applying that dollar value to adjust rates at varying levels.

D. Rebase. AHCCCS shall rebase the outpatient fees every five years.

E. Statewide CCR. The statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing, at which time AHCCCS may consider recalculating the statewide CCR based on the costs and charges for those services excluded from the outpatient hospital fee schedule.